Authorization for Medical Care and Recognition and Assumption of Risk Agreement

This authorization covers ____________________________ during his/her travel to and participation in ______________________________. This activity covers the period __________ through _________.

I, the undersigned parent or person or the legal guardian of the above-mentioned 4-H member, authorizes their participation in the listed event. In giving this consent I recognize and understand that precautions will be taken to safeguard the health and welfare of all who attend. However, in consideration of allowing said child to attend and participate in this activity, it is my understanding that participation in the activities that make up this event are not without some inherent risk of injury. As such, in consideration of my child's participation, I do hereby release, waive, discharge, and covenant to not sue the event, its organizers, the Oklahoma 4-H program, Oklahoma State University, Langston University, the Oklahoma Cooperative Extension Service, the State of Oklahoma or their officers, servants, agents, or employees and release them from any liability, claims, demands, and causes of action whatsoever arising out of or related to any loss, damage, or injury including death, that may be sustained by my child while participating in such activity, or while in, on, or upon the premises where the activity is being held (the provisions of the Oklahoma Governmental Tort Claims Act not withstanding).

In giving this consent I recognize and understand that in situations where the above named minor requires immediate medical or hospital care it may not be possible to contact me, and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment; in such situations, I authorize a physician, surgeon or dentist to exercise his professional judgment and assess the risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgment determines to be necessary for the health and safety of the above named minor. **I furthermore understand that an accident insurance policy carried by American Income Life http://www.americanincomelife.com/who-we-serve/4-h-insurance#fourh Plan __________, if any, will provide only minimum coverage and that I will be responsible for costs associated with the care and treatment of the above-mentioned child.**

CONTACT INFORMATION

Work Phone ( ) ________________________ Home Phone ( ) ____________________________

Cellular Phone ( ) _______________________ E-mail ______________________________________

Address ____________________________________ County ______________________________________

City _____________________________________ State ___________ Zip Code _________________

Family Medical Insurance Company ____

Policy Number _________________________________ Policy Holder's Name ___________________________

TREATMENT INFORMATION

Delegate's Birth Date _______________________________Gender _______________

Delegate's Allergies ____

____

Family Doctor ____ Phone ( ) _____________________

Other Doctor ____ Phone ( ) _____________________

Medicine delegate is taking ____

____

Date of Delegate's last Tetanus Shot ____

Delegate's Medical History (diabetes, asthma, etc.)

____

If the delegate has a serious medical condition or is under a doctor's care, a letter from the doctor should be attached outlining the nature of the condition, treatment or medical history.

I ACKNOWLEDGE that I have been provided a copy of the Notice of Health Information Practices as outlined in 45 CFR 164. I further acknowledge that this is general information and that I will be asked to acknowledge specific information by the provider. If emergency personnel are unable to locate the individual(s) listed above, and the minor cannot provide self-consent, the minor who presents with an urgent problem shall receive treatment as necessary at the discretion of the physician on duty.

PARENT'S SIGNATURE:____ Date ____________________

(of parent or person having legal custody or legal guardianship)

DELEGATE'S SIGNATURE: ________________________ **WITNESS** ______________________________________

OKLAHOMA 4-H CODE OF CONDUCT AND
MEMBER DISCIPLINE POLICY FOR DISTRICT, STATE, NATIONAL AND INTERNATIONNAL EVENTS

Name of 4-H Member ______________________________ Name of 4-H Event ______________________________

I. In seeking uniformity in the conduct expected at each district, state, national, and international event, the following guidelines have been developed to become effective on October 1, 1992.
   1. All rules and regulations governing an activity or event will be discussed with educators, leaders and 4-H'ers prior to or at the beginning of each event.
   2. All 4-H'ers are under the supervision of any Extension worker or adult assigned to the event.

II. 4-H'ers accused of any of the following will be required to appear before a review board:
   - Assault or personal harm
   - Possession or use of illegal drugs, alcoholic beverages, or 3.2 beer
   - Sexual misconduct
   - Theft, misuse or abuse of public or personal property
   - Possession of weapons

   If a question regarding any the above is raised, I agree to a search of my room and/or personal property. Failure to comply will result in violation of the Code of Conduct.

III. If the 4-H'er is found in violation of Section II, and receives discipline issued by the review board his or her parent/guardian will be notified immediately; the 4-H'er will be suspended from participation in district, state, national and international 4-H activities for a period for up to twelve 12 months and may be sent home immediately at parent's expense.

IV. 4-H'ers accused of any of the following may be required to appear before the review board:
   - Breaking curfew, disturbing the peace or violating the dress code
   - Use of abusive language
   - Unexcused absence from the activities of the even
   - Unauthorized use of vehicles during the event
   - Unauthorized absence from the premises of the event
   - Possession of illegal fireworks

   No boys will be allowed in girls' rooms nor will girls be allowed in boys' rooms, either as individuals or groups. It is recognized that circumstances may arise for justifiable exceptions to this policy. However, in every case, permission for exceptions must be secured from chaperone in advance.

   Use of tobacco in any form is discouraged at all 4-H events. No smoking, chewing, or dipping will be permitted at any scheduled meeting or activity. Legally possessed tobacco may only be used in designated locations.

V. If the accused 4-H'er is found in violation, of Section IV, and receives discipline issued by the review board, his or her parent/guardian will be notified, and the 4-H'er may be sent home immediately at the parents' expense and may be suspended from participating in district, state, national and international 4-H activities for up to six (6) months.

VI. Realizing these guidelines are not "all inclusive", the Extension Service reserves the right to make adjustments to policies.

VII. STAFF NOTIFICAITON PROCEDURES: If a 4-H'er is found in violation of the Code and is to be sent home, the person in charge of the event will notify the appropriate County, District or State 4-H Office.

VIII. REVIEW BOARD: The person in charge of the event will appoint a review board at the beginning of the event The review board will consist of the following:
   - At least one Extension educator, up to two Volunteer Leaders and three 4-H members (The person in charge of the event or delegation shall serve as chairman.)
   - The review board may be convened by the person in charge of the event/delegation, or at the request of the affected 4-H'er.

IX. APPEAL PROCEDURES: If a 4-H'er wishes to appeal the decision of the review board, he/she must appeal in writing through their County Extension Office. Appeals must be filed within 30 days following notification of punishment. As necessary, the State 4-H Leader shall appoint an appeal board, no sooner than 30 days following the date of notification of the disciplinary action. The appeal board who hears the appeal of the 4-H member shall consist of:
   - A County Extension Educator
   - A 4-H Volunteer
   - Two 4-H members
   - District 4-H Specialist

****

As a condition of participation in 4-H events, we agree to be bound by the terms of the 4-H Code of Conduct. We understand the reason for this agreement is to insure conduct and behavior that will result in every 4-H delegate receiving the full benefit of enjoyment and educational experience from this event and is not intended to place undue restriction upon any individual.

4-H Member Signature ____ Date _________________________

Parent or Guardian Signature ____

County Extension Educator ______________________________________ County _______________________

(NOTE: Failure to have the bonafide signatures above shall be sufficient reason to disqualify a member from further participation in a 4-H event. Please return entire page by designated date.)

Address ____ Phone ______________________

Where Parent or Guardian may be reached ____

To be provided to 4-H members/families in conjunction with the 4-H Code of Conduct and Authorization for Medical Care and Recognition and Assumption of Risk Agreement.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

If while on this or another 4-H function you require medical care, the healthcare provider will require parental consent before providing care beyond actually emergency care. You will be provided a form similar to this one that outlines the federally mandated information for you about your records. You will be asked to acknowledge that you have been provided the information from that specific provider. The information provided is generic and is being provided for information only.

Each time you visit a healthcare provider; a record of your visit is made. Typically, this record contains your identification, symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information is contained in your medical record and serves as a:

- basis for planning your care and treatment
- means of communication among many health professionals who contribute to your care
- legal document describing the care you received
- means by which an insurance company can verify that services billed the provider actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which the provider can assess and continually improve the care and outcomes the provider achieves

PROVIDER'S RESPONSIBILITIES

The provider is required to:

- maintain the privacy of your health information
- provide you with a notice (this document) as to our duties and practices with respect to information the provider collect and maintain about you
- abide by the terms of this notice
- notify you if the provider are unable to agree to a requested restriction

The provider reserves the right to change their practices and to make the new provisions effective for all protected health information they maintain. Should their information practices change, they will amend this notice to reflect those changes. By law they will not use or disclose your health information without your authorization, except as described in this notice.

YOUR INFORMATION RIGHTS

Understanding what is in your record and how your health information is used helps you to:

- ensure it accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing discloser to others.

Although your health record is the physical property of the provider, the information belongs to you. According to 45 CFR 164.522, you have the right to:

- request a restriction on certain uses and disclosures of your information
- inspect and be provided with a copy of your health record
- add an amendment to your health record
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the Administrative Director of the providing facility. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Treatment
Information obtained by a nurse, practitioner, or other member of the healthcare team will be recorded in your record and used to determine the course of your treatment. Members of the healthcare team will record the actions they have taken and their observations.

Payment
A bill may be sent to you, an insurance company, or the person responsible for paying your account. This may include information that identifies you, your diagnosis, procedures and supplies used. For some 4-H events medical coverage may be provided, however, you are ultimately responsible for your medical costs.

Directory
Your name may be posted in a facility directory as a patient and provided to others who ask for you by name unless you object.

Healthcare Operations
Members of the medical/administrative staff, the risk or quality improvement team may use information in your health record, combined with others like it, to assess care and outcomes. This information will then be used in an effort to continually improve the quality of the healthcare and services the provider provide.

Business Associates
There are some services provided in our organization through contacts with business associates. When these services are contracted, the provider may disclose your health information to our business associate so that they can perform the job The provider have requested. An example of this would be sending a test to an outside reference laboratory for processing. To protect your health information, the provider requires the business associate to appropriately safeguard your information.

Notification
The provider may use or disclose information to notify you; or notify a family member, personal representative, or another person responsible for your care, in order to obtain your location, as a way to ensure your condition, or to determine if referral care was completed.

Communication with Family/Others
Health professionals, using their best judgment, may disclose to a family member, or other relative, close personal friend or many other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food and Drug Administration
The provider may disclose to the FDA health information relative to adverse events with respect to food, supplements, product or product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Public Health
As required by law, the provider may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement
The provider may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. The provider may disclose to law enforcement officials upon request, information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person or information about an individual who is, or is suspected, to be a victim of a crime.

Inspections
Your health information may be used by members of appropriate health oversight agencies, public health authorities including the State Department of Health inspection teams in order to determine that the provider follows professional and clinical standards and is not endangering patients, workers, or the public.